Centers for Medicare & Medicaid Services

LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM
INTERRUPTED STAY FACT SHEET

JULY 2003

What Is An Interrupted Stay?

An interrupted stay occurs when an LTCH patient is discharged from a long-term care hospital and is directly admitted to a specific type of Medicare provider (an inpatient acute care hospital, an inpatient rehabilitation facility, or a skilled nursing facility/swing bed), then returns to the original long-term care hospital within a specified period of time. This specified period of time, also called a fixed-day period, varies depending on the type of facility that receives the patient from the long-term care hospital. The following table lists the fixed-day periods for each type of facility:

Facility Type	Fixed-Day Period
Inpatient Acute Care Hospital	9 days or less
Inpatient Rehabilitation Facility	27 days or less
Skilled Nursing Facility/Swing Bed	45 days or less

To meet the full definition of an interrupted stay, the patient must also be:

- § Discharged directly from the long-term care hospital and admitted directly to an inpatient acute care hospital, an inpatient rehabilitation facility, or a skilled nursing facility/swing bed.

AND

- § Discharged back to the original long-term care hospital after a length of stay less than or equal to the applicable fixed-day period.

If a patient returns to the LTCH within the fixed-day period and fulfills the criteria above, the episode of care at the LTCH is considered an interrupted stay and one LTC-DRG payment will be made based on the initial admission. A case may have multiple interrupted stays, but each stay must be evaluated separately to make certain that it meets the interrupted stay criteria. Cases with interrupted stays may also be eligible for other case-level adjustments (for example, the case may also be eligible for a short-stay outlier payment).

Background

Under the Medicare system, long-term care hospitals (LTCHs) generally treat patients who require hospital-level care for an average of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for long-term care hospitals. The new payment system, the long-term care hospital prospective payment system (LTCH PPS), replaces the current cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA).

What Are Long-Term Care-Diagnosis Related Groups?

The LTCH PPS uses long-term care-diagnosis related groups (LTC-DRGs) as a patient classification system. Each patient stay is grouped into an LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status. Each LTC-DRG has a pre-determined average length of stay (ALOS), or the typical length of stay for a patient classified to the LTC-DRG. Under the LTCH PPS, an LTCH receives payment for each Medicare patient, based on the LTC-DRG to which that patient's stay is grouped. This grouping reflects the typical resources used for treating such a patient. Cases assigned to an LTC-DRG are paid according to the Federal payment rate, including adjustments. One type of case-level adjustment is an interrupted stay.

What Is Not An Interrupted Stay?

Not all patient discharges to another Medicare provider meet the definition of an interrupted stay. The following examples are not interrupted stays:

- The patient has a length of stay at the receiving facility (an acute care inpatient hospital, an inpatient rehabilitation facility, or a skilled nursing facility/swing bed) that exceeds the fixed-day period for the facility type.

Example:

A patient is discharged from the long-term care hospital and then is admitted to an acute care hospital. The patient then returns to the same long-term care hospital after 10 or more days. The return to the long-term care hospital is a new admission.

- The patient is discharged to a type of facility other than the four types of facilities previously mentioned.

Example:

A patient is discharged from the long-term care hospital and then is admitted to care provided by a home health care agency. The return to the long-term care hospital is a new admission.

- The patient is discharged to more than one facility.

Example:

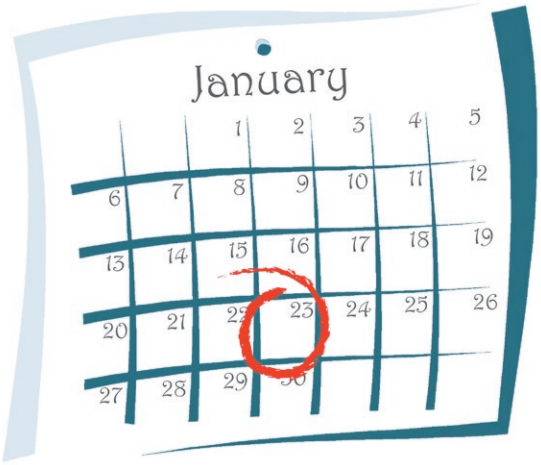
A patient is discharged from the long-term care hospital, is admitted to an inpatient rehabilitation facility, and then is discharged from the inpatient rehabilitation facility to an acute care hospital. Finally, the acute care hospital discharges the patient to the original long-term care hospital. The return to the long-term care hospital is a new admission.

- The patient returns home between long-term care hospital stays.

In all of the scenarios above, if a stay disruption does not meet the definition for an interrupted stay, the original discharge ends the patient's stay. If the patient is readmitted to the facility, the second admission begins a new stay. The long-term care hospital would receive two LTC-DRG payments for two patient stays: one payment for the first stay, and a separate payment for the stay after the readmission to the long-term care hospital.

There are no current separate policy provisions regarding transfers between long-term care hospitals. The admissions to each long-term care hospital are treated as separate cases. The Centers for Medicare & Medicaid Services (CMS) will be monitoring such discharges.

If the patient's stay meets the interrupted stay criteria, the principal diagnosis should not be changed when the patient returns to the LTCH from the receiving facility. If other medical conditions are apparent upon the patient's return to the LTCH, the additional diagnosis codes should be noted on the claim.



How Are Days Counted Under The Interrupted Stay Policy?

The interrupted stay day count begins on the day of discharge from the long-term care hospital and continues until the 9th, 27th, or 45th day after the discharge (depending on the facility type). If an interruption in the patient's stay at a long-term care hospital meets the interrupted stay criteria, the days prior to the original discharge from the long-term care hospital will be added to the number of days following the readmission the length of time at the receiving Medicare provider. The days before and after an interrupted stay determine the total length of stay for the episode of care.

Example:

A patient is admitted to a long-term care hospital on 11/1/02 and discharged to an acute care hospital on 11/8/02. The

patient returns to the long-term care hospital on 11/14/02. Since the time between the discharge to the acute care hospital and the return to the long-term care hospital is 7 days, the stay meets the fixed-day period requirement for acute care hospitals. This example is an interrupted stay case for the long-term care hospital. The first 8 days of the LTCH stay (11/1/02 through 11/8/02) will be added to the day count of the second portion of the LTCH stay. Depending on the accumulated length of the stay, the LTCH will receive either a short-stay outlier payment or a full LTC-DRG payment for the case.

LTCH PPS Final Rules

CMS published three Final Rules affecting Medicare payments to LTCHs on the following dates:

August 30, 2002 - the first LTCH PPS Final Rule was published, formalizing the policies and procedures for the new LTCH prospective payment system.

June 6, 2003 - the first update of the LTCH PPS Final Rule was published, changing the update cycle for future LTCH PPS updates, and revising several payment rates for the LTCH PPS, including the fixed-loss amount.

June 9, 2003 - the Outlier Final Rule was published, affecting payment calculations for outlier cases. This Final Rule provided several changes to the application of the CCR, as well as changes to outlier payment reconciliation policies.

How Are Interrupted Stay Payments Determined?

Unlike other case-level adjustments, billing instructions determine payment for interrupted stays. Interrupted stay payments (based on the co-location policy discussed in the next section) are determined by the Fiscal Intermediary at the cost-report settlement.

Are There Any Special Policies For Co-located Providers?

If a long-term care hospital is onsite (co-located) with another Medicare provider (for example, a hospital-within-in-a-hospital or a satellite facility located within another provider), a special interrupted stay payment policy may apply to LTCH patient discharges between the co-located facilities. CMS created this special payment policy to discourage unnecessary patient shifting between providers that share a physical location. Under the policy, if the number of discharges and readmissions between a long-term care hospital and a co-located provider exceeds 5% of the total discharges during a cost reporting period, only one LTC-DRG payment will be payable to the long-term care hospital for all such discharges and readmissions. This payment policy applies to discharges before and after the threshold is exceeded. There are two distinct 5% thresholds, as shown in the following tables:

Co-Located Provider Policy For Onsite Acute Care Hospitals

If…	*Then…*
During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite acute care hospital. . .	*The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.*

Co-Located Provider Policy For Onsite Inpatient Rehabilitation Facilities, Skilled Nursing Facilities/Swing Bed, or Psychiatric Facilities

If…	*Then…*
During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite inpatient rehabilitation facility, a skilled nursing facility/swing bed, or a psychiatric facility (or any combination of the above). . .	*The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.*

Providers must inform their Fiscal Intermediaries and their CMS Regional Office about any co-located facilities within 60 days of the start of the long-term care hospital's first cost reporting period beginning on or after October 1, 2002, or within 60 days of any change in co-location status.

Where Can I Find More Information About The LTCH PPS?

The following online references provide more information about the LTCH PPS:

§ The Medicare Learning Network LTCH PPS Web Page

http://www.cms.hhs.gov/medlearn/ltchpps.asp

The Medicare Learning Network features CMS provider education materials for the LTCH PPS, including the *CMS Long-Term Care Hospital Prospective Payment System Training Guide.*

§ Long-Term Care Hospital Web Page

http://www.cms.hhs.gov/providers/longterm/default.asp

The Long-Term Care Hospital Web Page provides the Final Rules and additional LTCH PPS related documents, including a Frequently Asked Questions List. The Web site also provides instructions on joining the LTCH PPS mailing list, which provides the latest LTCH PPS news and updates.

§ LTCH PPS Program Memorandum

http://www.cms.hhs.gov/manuals/pm_trans/A02093.pdf

Instructions for Fiscal Intermediaries implementing the LTCH PPS system can be found in Program Memorandum A-02-093, *Instructions for Implementing the Long-Term Care Hospital Prospective Payment System,* dated September 27, 2002.

Questions about interrupted stays and the long-term care hospital prospective payment system can be emailed to ltchpps@cms.hhs.gov.

Where Can I Find More Information About ICD-9-CM Coding?

The LTCH PPS Final Rule emphasized that proper coding is essential for correct diagnosis and procedure reporting. The following online references provide ICD-9-CM coding guidance:

§ The ICD-9-CM Official Guidelines for Coding and Reporting

http://www.cdc.gov/nchs/data/icd9/icdguide.pdf

The LTCH PPS Final Rule stated that the *ICD-9-CM Official Guidelines for Coding and Reporting* is essential reading for understanding how to report the proper diagnosis and procedure codes that are used in determining the LTC-DRG payment amounts.

§ Updates to the ICD-9-CM Diagnosis and Procedure Codes

http://www.cms.hhs.gov/paymentsystems/icd9/default.asp

This Web site identifies the activities (including public meeting schedules and agendas) of the ICD-9-CM Coordination and Maintenance Committee charged with maintaining and updating the ICD-9-CM coding system.